PATIENT INFORMATION FORM

PATIENT/DEPENDENT INFORMATION

Name: ________________________________ DOB: ______________ Social Security # ____________________
Address: ____ City/State: ____________________ Zip: ____________
Home: __________________ Work: __________________ Mobile: __________________
Gender: Male ___ Female ___ Marital Status: Single ___ Married ___ Other ______________
Please check one: Employed ___ Full-time Student ___ Part-time Student ___
Employer Name/Address: ____
Emergency Contact Name/Number:____

RESPONSIBLE PARTY INFORMATION

Name: ________________________________ DOB: ______________ Social Security # ____________________
Address: ____ City/State: ____________________ Zip: ____________
Home: __________________ Work: __________________ Mobile: __________________
Gender: Male ___ Female ___ Marital Status: Single ___ Married ___ Other ______________
Please check one: Employed ___ Full-time Student ___ Part-time Student ___
Employer Name/Address: ____
Relationship to Patient: Husband ___ Wife ___ Child ___ Parent ___ Other ________________

INSURANCE INFORMATION

Primary Insurance: ___________________________________ Phone: _____________________
Insured Name: _______________________________ Relationship to Patient: _______________ DOB: __________
ID# _________________________ Group # ______________________ Is this through your employer: **Yes No**
Secondary Insurance: ___________________________________ Phone: _____________________
Insured Name: _______________________________ Relationship to Patient: _______________ DOB: __________
ID# _________________________ Group # ______________________ Is this through your employer: **Yes No**

ASSIGNMENT

I request that payment of authorized benefits be made either to me or on my behalf to Chenal Family Practice for nay services furnished to me. I authorize any holdings of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits of the benefits payable for related services.

____ _______________

Signature of Patient/Authorized Representative **Date**

PATIENT QUESTIONAIRE

CHIEF COMPLAINTS (what are any new medical concerns or goals you have not including anything in your current medical history) ***3 items at most please***

1)____

2)____

3)____

PAST MEDICAL HISTORY: Hypertension High Cholesterol Diabetes Asthma Allergies
Other:
____

PAST SURGICAL HISTORY: Tonsillectomy Appendectomy Gallbladder C-section Tubal Ligation Vasectomy
Other:
____

HABITS: Tobacco for _____ years of life Alcohol _____ drinks per day/week

DRUG ALLERGIES: ____
____

MEDICATIONS (list all meds and doses)

Medication	Dosage	Condition used for

SOCIAL HISTORY: Single Married Divorced Widowed Significant Other
Occupation: ___________________________________

FAMILY HISTORY: **Diabetes** -- Father/Mother/Brother/Sister **Coronary Artery Disease** -- Father/Mother/Brother/Sister

IMMUNIZATIONS (most recent year): TDap ________ Pneumo ________ Influenza ________

GYN: Pregnancies # _____ Births # _____ Miscarriages # _____ Abortions # ______
Last Pap Smear: _______ Last Menstrual Period: _______ Last Mammogram (if over 40): ______

CHENAL FAMILY PRACTICE
PATIENT AGREEMENT

In order to maintain compliance with the Arkansas State Medical Board Medical Practice Acts & Regulations; Reg. No. 2, I understand and agree to the following conditions of my medical care:

1) Keep my medication card/information updated and bring it with me to each office visit.

2) Keep each scheduled appointment or call and cancel/rescheduled as soon as possible.

3) Maintain compliance with my medical treatment and/or evaluations as recommended by my primary care physician.

4) I will not accept or fill prescriptions for any DEA scheduled medications, such as Narcotics, Benzodiazepines, and Amphetamines, unless my primary care physician is aware of it.

5) I hereby give my physician consent to treat me with all medications deemed medically necessary, including DEA controlled substances, if the physician deems medically necessary for therapeutic reasons.

____

Patient Name (Printed)

____

Patient Signature   Date

CHENAL FAMILY PRACTICE

Patient Name: ___________________________________

Date of Birth: ___________________________________

Social Security Number: ___________________________

In an effort to comply with current HIPAA (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information:

Please list any persons other than your doctor with whom we may discuss your private health information or financial matters:

Name____________________________ Phone_______________ Relationship____________

Name____________________________ Phone_______________ Relationship____________

Name____________________________ Phone_______________ Relationship____________

In the event that we are unable to reach you personally, do you give your permission for Dr. _______________ or one of his office staff to leave a message on your answering machine and/or leave a message with someone at your home phone number concerning your private health information or financial matters?

YES ____ NO ____

In accordance with HIPAA standards, CHENAL FAMILY PRACTICE has a document called the "Notice of Privacy Practices"

____

____ ________________________________

Patient or legally authorized individual signature Date

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)
____